2012

INTERIM REPORT

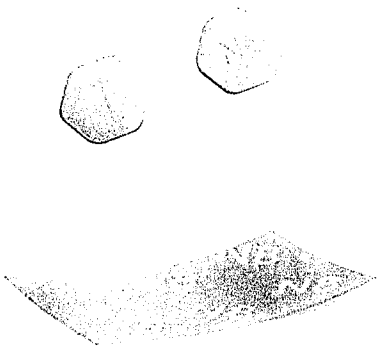
Prepared for LHHS Committee , November 26, 2012

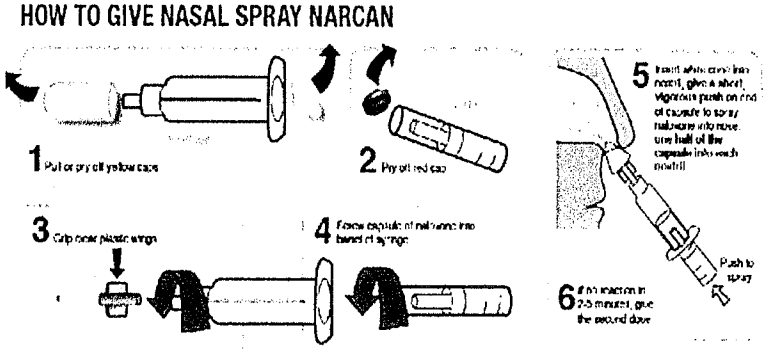
Senate Memorial 45 Study Group

Harm Reduction Related to Opioid Use and Dependency

INITIAL RECOMMENDATIONS:

Naloxone and Syringe Exchange & Medication Assisted Treatment





Report compiled on behalf of the
Senate Memorial 45 Harm Reduction Study Group by the
Robert Wood Johnson Foundation Center for Health Policy
at the University of New Mexico

SM45 INITIAL REPORT FOR THE LHHS COMMITTEE

TABLE OF CONTENTS

SM45 - INITIAL REPORT OF THE

NALOXONE/SYRINGE EXCHANGE PROGRAM SUBCOMMITTEE

Emergency – New Mexico continues to Lead Nation in Fatal Drug Overdoses-- More than Two Times the National Average.

BACKGROUND

New Mexico is facing opioid overdose death rates of unprecedented proportions. This epidemic is both a devastating personal tragedy to every family that has lost a loved one and a public health crisis for our state. We are losing our children, our parents and our grandparents. Since 1991, the drug overdose death rate has increased 242%.

And while the face of overdose has traditionally been that of a heroin user, overdose is also dramatically impacting senior citizens and middle-aged New Mexicans who are increasingly overdosing from prescription pain medications. These classes of drugs are referred to as opioids.

An analysis of 1,812 unintentional drug overdose deaths recorded in New Mexico (2005-2009), about 60% involved illicit drugs and 40% involved prescription drugs, principally opioid painkillers.[1]

Proven strategies are available to reduce the harms associated with drug use, treat dependence and addiction, improve immediate overdose responses, enhance public safety and prevent fatalities. Notably, the drug naloxone, if administered in an opioid overdose situation, can rapidly reverse the effects of the drug and save a life.

New Mexico has been a national leader in the use of harm reduction strategies to prevent overdose fatalities, being first with public programs promoting the distribution and use of naloxone, and having a Good Samaritan law. Evidence suggests there have been hundreds of lives saved in New Mexico because of the Department of Health's harm reduction program.

However, the ongoing epidemic of opioid overdose deaths indicates that the current efforts have not been sufficient. The opioids that are causing the overdoses are not about to disappear from use. The most direct way of combating the continuing high rate of overdose deaths is to greatly expand the distribution, availability, and use of naloxone.

---

1. New Mexico Department of Health. *New Mexico Substance Abuse Profile*. July 2011.

The Subcommittee feels the current situation should be managed as an emergency in order to deploy the steps necessary to achieve the needed level of expansion of use of naloxone for out-of-hospital life-saving rescues.

The following recommendations are evidence-based solutions to take us to the next level in responding to New Mexico's overdose crisis with rational, compassionate and responsible public health policies.

Naloxone (Narcan®) Recommendations

Naloxone hydrochloride (Narcan®) is an opioid antagonist that is used to successfully reverse an overdose caused by any opiate including heroin or prescription opioids such as hydrocodone, oxycodone, methadone and morphine. While not classified as a controlled substance, Naloxone requires a prescription and may be dispensed only by a pharmacist or licensed provider. It is not available over-the-counter. Naloxone is not addictive and produces no pharmacological effects if the individual has not taken opioids.[2]

RECOMMENDATIONS TO ESTABLISH/INCREASE PHARMACIST PRESCRIBING AUTHORITY/ PHARMACY ACCESS, AND MONITORING

1. DOH, in partnership with the NM Pharmacy Board, community-based medical systems and pharmacies will continue to develop, evaluate, and enhance current pilot projects where local pharmacies procure intranasal naloxone for dispensing under prescription to persons to be at risk for overdose

2. The NM Board of Pharmacy, in conjunction with the other licensing boards, and in consultation with the DOH, should develop and approve a protocol and training curriculum allowing pharmacists to prescribe naloxone.

RECOMMENDATIONS FOR PROVIDER EDUCATION AND CO-PRESCRIBING WITH NALOXONE WITH OPIATES

1. In conjunction with currently mandated education of prescribers on pain management, include training about harm reduction strategies and specifically on the recent guidelines that have been reviewed by DOH and others and specify when a patient should receive education about risk of opiate overdose and about co-prescription of naloxone. These guidelines serve as a starting point and should be periodically reviewed and expanded to reach as much of the population that is at risk as possible.

2. The DOH should promulgate training and education to rural providers in community health centers, relative to harm reduction in primary care setting, to include clinical guidelines for the provision of the rescue medication naloxone, under prescription, to persons at risk of overdose from their opioid pain medication.

RECOMMENDATIONS FOR EXPANDED ACCESS TO NALOXONE AND SYRINGE SERVICES PROGRAMS

---

2. *The International Journal of Drug Policy*, April 2001

1. Continue to work with Medicaid to expand coverage to include outpatient naloxone.

2. Require commercial insurance to pay for naloxone when used as co-prescription given to patients who are being prescribed opioids and who meet guidelines (which now exist) for being at risk for overdose. (This may take legislation.)

3. Health insurance offered through the Health Insurance Exchange and Medicaid must specify coverage for outpatient naloxone as a covered benefit. Health plans must make naloxone available as an option as a condition for being qualified within the Health Insurance Exchange and for contracting as managed care organizations for Medicaid. (Legislation may be needed if Division of Insurance, Office of Health Care Reform, and/or Medicaid cannot ensure.)

4. DOH and local county administrations, in partnership with the Association of Counties, should develop pilot programs for providing naloxone to inmates who use or previously used opiates at time of release from incarceration. Similarly, the Corrections Department should make naloxone available to inmates at time of release. More broadly, provide naloxone to high-risk individuals and families involved in the criminal justice system since individuals are at higher risk for opiate overdose due to potential lowering of opiate tolerance even if incarcerated for short periods of time.

5. DOH to research the option of expanding the capacity of local public health offices so that non-clinical staff can dispense naloxone. This would be a shift in protocol so that public health nurses do not have to be present to dispense naloxone.

6. Request $1,000,000 in funding in support of the DOH Harm Reduction Program: $700,000 to restore funding to previous levels; and, $300,000 in increased funding to account for the expansion of services in response to the increased need.

    a. $700,000 - Restore program supply funding in order to ensure proper protective supplies and material can be distributed to program participants.
    b. $300,000 –
        i. Additional hours of contract services, including nursing services to provide overdose prevention education and dispense naloxone at medical agencies and other community based organizations that provide syringe exchange services
        ii. Create a health educator position for the Harm Reduction Program in order to promote overdose prevention activities, including training of staff and community partners on distribution and use of naloxone as well as recruiting and expanding partner locations to deliver these services.

7. Syringe exchange sites offer a point of access for distribution of naloxone. Eliminate the age restriction for participation in Syringe Services Programs (SSP).

SM45 – INITIAL REPORT OF THE

MEDICATION ASSISTED TREATMENT SUBCOMMITTEE

Addiction— whether to alcohol, illicit drugs, or prescription drugs—is a chronic medical disease of the brain that is treatable. (NIDA)

Acceptance and application of this fundamental concept is essential in successfully dealing with persons with drug use disorders, in particular managing behaviors and health effects associated with their drug use. Failure to do this means that problems will have increased likelihood of continuing, often with ruinous consequences to person and family, impacting community, burdening the health care and criminal justice systems, all at enormous public cost.

BACKGROUND

The Department of Health estimates as many as 200,000 abusers of illicit or prescription drugs in New Mexico, with at least 23,000 of those being injection drug users. There is a particular problem with persons misusing or abusing prescription opioid pain medications, with the rates of dependency and unintentional overdose deaths have tripled over the past decade.

Among the opportunities now possible within the existing health care structure to help persons with opioid addiction is medication assisted treatment (MAT).[3]

MAT is therapy with either methadone or buprenorphine and is one important component of the continuum of care for restoring persons with opioid addiction to stable and productive lives. Given the high risks including risk of death involved with opioid addiction, MAT can be lifesaving.

Methadone is itself an opioid drug but has a substantially reduced euphoric effect compared with opioids of abuse. Because it stays in the body and on the receptors for a prolonged period of time, it tends to inhibit the effect of other opioids that are abused. It also reduces cravings for other opioids and reduces the overdose rate from injected opioids. Methadone for purposes of MAT is distributed only in federally certified clinics where clients receive their treatment once a day directly observed by clinic staff,

---

3. MAT has been a topic of study by the 2011 Senate Memorial 18 Drug Policy Task Force as well as the 2012 Senate Memorial 45 Harm Reduction Study Group.

guaranteeing documented compliance. There are only eleven certified clinics in New Mexico: eight in Albuquerque and one each in Espanola, Santa Fe, and Las Cruces.

Buprenorphine has opioid properties but blocks the effects of other opioids, reducing or eliminating cravings for opioids of abuse. The most common formulation of buprenorphine is Suboxone®. It is taken under the tongue one to two times a day with prescriptions given only by physicians (typically primary care physicians) who have undergone a specialized eight-hour training course and have received a waiver from the Drug Enforcement Administration to write prescriptions for it. Directly observed therapy is not required.

Medicaid in New Mexico covers physician visits for methadone and buprenorphine and the drugs themselves. Coverage may require prior authorization and may require frequent renewal.

In 2009 the Substance Abuse and Mental Health Services Administration published an analysis that demonstrated that, on average, each dollar invested in treating drug addiction yields a savings to the public of $12 in medical and criminal justice costs. The costs of MAT in particular are overwhelmingly offset by cost savings in terms of reduced medical complications of addiction, related criminal behavior, criminal justice proceedings, subsequent incarceration, and social costs and in terms of restored families and economic productivity.4 Methadone returns on average at least $4 for every dollar invested in treatment just with respect to reductions in crime and incarceration.5

PROBLEM 1: INSUFFICIENT NUMBER OF PHYSICIANS TO TAKE ON PATIENTS WHO WOULD BENEFIT WITH MAT.

NM is favored in having some physicians who offer MAT with buprenorphine in their practices. These few physicians, however, are able to address only a small fraction of the population that might benefit.

Barriers and disincentives presently severely constrain the availability of MAT in New Mexico.

a. Methadone clinics are few in number and available only in Albuquerque (5), Espanola (1), and Las Cruces (1).
b. Only a few physicians choose to take the required training for certification to administer buprenorphine. Even with certification, only a few physicians take on

---

4. Connock M, Juarez-Garcia A, Howett S, et al. Methadone and buprenorphine for the management of opioid dependence: a systematic review and economic evaluation. *Health Techno Assess.* 2007: 11: 1-171 iii-iv.
5. Harwook HJ, Hubbard RL, Collin JJ, Rachal JV. The costs of crime and the benefits of drug abuse treatment: a cost-benefit analysis using TOPS data. In: *Compulsory Treatment of Drug Abuse: Research and Clinical Practice* (NIDA Research Monograph Series). Rockville, MD: DHHS, 1988.

patients for MAT. Reasons are multifold: many simply have distaste for caring for persons with opioid use disorders or don't want them in their offices or clinics; addiction is a chronic illness often associated with co-occurring mental disorders, and management is challenging, time consuming, and frustrating; over time, many patients relapse and some return to illicit opioid use; and many physicians feel that reimbursement is insufficient for the time and effort likely to be needed; (some physicians have been outspoken in their decision to have a policy of not managing patients with substance use disorders). Also: lack of adequate training/orientation toward addiction as a chronic disease in their medical training; opposition from clinic administrators; and physicians with certification are limited by regulation in the numbers of patients to be managed at one time – up to 30 patients at one time or up to 100 if there support services are available.

c. Successful management with MAT requires concurrent counseling and often requires social support (wrap-around) services that may be insufficiently available to many primary care physicians or not covered under current financing of health care.
d. There is a black market for Suboxone® and it has street value for opioid users. The possibility of diversion is a concern for some prescribing physicians. (Illicit use of Suboxone® is likely driven for the same reason that the drug is used clinically, namely it is a substitute for other addictive opioids, and it is difficult if not impossible to obtain legitimate access.)[6]
e. Some physicians are put off by onerous preauthorization and reauthorization processes and by the prospect of DEA audits of prescribing practices.

More broadly, physician incentives and rewards for this work are meager and insufficient to overcome the disincentives. Until this is addressed, it is unreasonable to expect enough physicians to simply step forward to for certification and participation.

Even patients who have insurance coverage who might benefit from buprenorphine may have to wait weeks or even months to find a physician who certified and willing to consider MAT, while it is inaccessible for almost all patients who are uninsured. A goal for New Mexico should be that every person with opioid use disorder has the opportunity for evaluation for suitability for MAT at the time the need for such assessment is identified and, if appropriate, have access to this important treatment option at that time.

The Subcommittee is looking to the health plans and the funding intermediaries to address the issue of incentives and to be the entities for ensuring that providers are certified and available to meet the needs of their enrolled patients for MAT. This needs to be among the contractual conditions they accept for holding the money for providing health care services.

With health the Affordable Care Act and the Health Insurance Exchange and with the

---

6. Bazazi AR, Yokell M, Fu J, et al. Illicit use of buprenorphine/naloxone among injecting and noninjecting opioid users. *J Addict Med.* 2011;5(3):175-180.

proposed changes in Medicaid, there are now unique opportunities to address this issue.

RECOMMENDATIONS RELATING TO HAVING HEALTH CARE PLANS AND OTHER PUBLICLY FUNDED SERVICES INCREASE AVAILABILITY OF PHYSICIANS DOING MAT:

1. Health insurance offered through the Health Insurance Exchange and Medicaid must specify coverage for treatment of substance use disorders as an essential health benefit so as to include MAT. (Legislation needed if Division of Insurance, Office of Health Care Reform, and/or Medicaid cannot ensure.)

2. Health plans must make MAT available as a treatment option as a condition for being qualified within the Health Insurance Exchange and for contracting as managed care organizations for Medicaid. The administering entities (i.e., the Insurance Division and the HIE itself and the Medical Assistance Division) must require that health plans ensure the availability of physicians who are certified and willing to treat patients with buprenorphine. Should an MCO have a local shortage of such physicians, it must provide access to an available certified physician out of network. (Legislation may be needed if Medicaid and other administering entities cannot ensure.)

3. Publicly funded health care purchasing authorities should offer benefit packages that meet or exceed the New Mexico's basic health benefit under ACA and the HIE. The Legislature should explore how the Health Care Purchasing Act may be used to articulate a basic health benefit be offered through the quasi-public health care purchasing authorities that would align with those used by in the HIE and Medicaid. Such basic health benefit should specifically include treatment of drug use disorders and include MAT.

4. Medical provider entities receiving grants, loans, appropriations or other direct support from the State for services that include primary care including community health centers and hospitals must be able to make MAT available as a treatment option as a condition for funding. An example would be community health centers. (Legislation may be needed if State agencies handling such support cannot ensure.)

In addition, given the magnitude of the need for providers of MAT, direct incentives would likely be impactful and cost effective.

5. Physicians who manage at least 80% of the full allowable number of patients on buprenorphine for a full year should be granted a tax credit, proposed at $5,000, up to a total of three years.

PROBLEM: State agencies need to expand programs that private sector are unlikely to reach.

RECOMMENDATIONS FOR STATE AGENCIES AND FOR PHYSICIAN TRAINING

1. The DOH should establish and maintain or arrange for programs to provide MAT in each DOH Region for persons without insurance based on local needs. This includes persons being released from incarceration. (This will likely require appropriation.)
2. DOH, HSD, CYFD should expand buprenorphine MAT and associated treatment services to persons <16 years old when deemed clinically indicated. (Within current capabilities of agencies.)
3. The HSD (BHSD) should create an online statewide service directory of buprenorphine providers, noting those currently accepting new patients for MAT.
4. Buprenorphine certification and direct experience providing MAT should be a requirement for any physician completing a NM residency in family practice or general internal medicine or completing training in NM leading to certification in pain management in NM. These recommendations should be considered for residents completing a residency in psychiatry, pediatrics, emergency medicine, or obstetrics/gynecology.
5. The UNM Health Sciences Center should take a lead in addressing the population burden of opioid dependency disorders.
6. Legislature needs to be responsive to funding requests that target these recommendations.

PROBLEM: PERSONS RELEASED FROM INCARCERATION ARE NOT GETTING TREATMENT

Approximately 87% of New Mexico prisoners have some kind of substance se disorder. Managing addictive disorders during and after incarceration substantially helps the prospects for reintegration and is associated with reduced rates of both substance use and criminal recidivism. More specifically, MAT is currently not available to inmates in the prisons. Studies have shown that prerelease MAT with counseling is associated with less post release heroin use, overdose, and criminal activity.[7] Studies show that prelease MAT can more than pay for itself when associated with close follow-up.

Funding constraints in recent years and budget cutbacks have led to reductions in addiction treatment services in the prisons. Research in the cost-benefit of drug dependency treatment indicates this is a false savings for the state.

RECOMMENDATIONS FOR MAT FOR PRISONERS AND PAROLEES WITH SUBSTANCE USE DISORDERS

1. In the context of restoring and building treatment programs for prisoners with substance use disorders, the Corrections Department in collaboration with the Department of Health and Human Services Department should plan for access to

---

7. Chandler RK, Fletcher BW, Volkow ND. Treating drug abuse and addiction in the criminal justice system. *JAMA*, 2009;301:183-190.

MAT management immediately upon the release of any prisoners identified as at risk for resumption of opioid use, to be piloted in 2013 with intent to implement generally by 2015.

2. Corrections Department and Medical Assistance Division should work to assure that persons being released from prison who will be eligible for Medicaid are enrolled effective upon the moment of release and are connected with a local care provider with access to MAT.
3. The Department of Health, coordinating with the Behavioral Health Services Division, should expand its programs to provide advice and technical assistance to county jails, performing evaluation on pilot sites, order to do the following:
   a. Make available continuing MAT for prisoners already on MAT at the time of incarceration, whether that be methadone or buprenorphine;
   b. Plan for access to MAT management immediately upon the release of any prisoners identified as at risk for resumption of opioid use (this is in addition to providing naloxone).
   c. Assure that persons being released from jail who will be eligible for Medicaid are enrolled effective upon the moment of release.

SM45
Subcommittee Memberships and Participating Advisors

Naloxone/Syringe Exchange Subcommittee

Emily Kaltenbach, Co-Chair	Drug Policy Alliance
Jeanne Block, Co-Chair	Project ECHO
Monica Ault	Drug Policy Alliance
Andrew Ganz	DOH, Harm Reduction
Melissa Heinz	DOH, Injury Prevention
Vivian Heye	Harm reduction volunteer
Deborah Reynolds	DOH, Hepatitis Harm Reduction
Olivia Sloan	Drug Policy Alliance
Bill Wiese	RWJF Center
Dominick Zurlo	Student

Medication Assisted Treatment Subcommittee

Harris Silver, Co-Chair	Physician
Bill Wiese, Co-Chair	RWJF Center
Miriam Komaromy	Project ECHO
Bernie Lieving	Southwest CARE Center

Medically Supervised Injection Facility Feasibility Subcommittee

Emily Kaltenbach, Co-Chair	Drug Policy Alliance
Steve Lucero, Co-Chair	Hispanic Medical Association

Technical Advisors

Anne Foster	Medicaid
Cliff Rees	Network for Public Health Law
Brad Whorton	DOH Epidemiology

NOTE AND DISCLAIMER

These draft recommendations are based on discussions by the SM45 Study Group's Naloxone/Syringe Exchange and MAT Subcommittees.

The views expressed in this document represent a consensus of the Subcommittees but have not been reviewed by all persons who have otherwise been contributing to the SM45 Study Group's work and others whose reviews have been requested, and are therefore preliminary.

Nor do the views expressed necessarily represent the Robert Wood Johnson Foundation Center for Health Policy, the University of New Mexico, or collaborating organizations or funders.

This Initial Report was edited, November 26, 2012 for presentation to the Interim Legislative Health and Human Services Committee.

Inquiries and comments may be sent to
William Wiese
Robert Wood Johnson Foundation Center for Health Policy
MSC02 1645
1 University of New Mexico
Albuquerque, NM 87131-0001

E-mail: wwiese@salud.unm.edu
Phone: 505-277-0130 or 505-277-1598